

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005215

STATE FILE NUMBER

AMENDED

Registration District No. 354

Primary Registration District No. 6199

Registrar's No. 7

FILED FEB 8 1962

1. PLACE OF DEATH a. COUNTY Texas				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Okla. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clinton twp.		Length of stay in 1b approx. 2 wks.		c. CITY OR TOWN Muskogee		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2 1/2 Mi. E. Mt. Grove			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 837 N. 3rd. Street		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last John Ira Scott				4. DATE OF DEATH Month Day Year approx. 1/11/62			
5. SEX male	6. COLOR OR RACE negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/20/96	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Abbeville, South Caro.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George W. Scott		13b. MOTHER'S MAIDEN NAME Lizzie Glover		14. NAME OF HUSBAND OR WIFE none			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Geo. Scott, Flint, Michigan			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) skull fracture & exposure probably 1 day				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) also, fracture of the right arm.							
DUE TO (c) Possibly fell from train or was trying to hop it.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> unknown	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) unknown. Deceased possibly fell from train					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	or fell while trying to hop it. Could have been pushed						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Frisco Railroad tracks	20f. CITY, TOWN, OR LOCATION Clinton two., Texas, Mo.		COUNTY		STATE	
21. I attended ^{VIEWED} the deceased from ^{ON} 1-25-62 , to approx. 12:45 and last saw her alive on 1-29-62 Death occurred at approx. 12:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree, or title) James P. Gentry, Coroner				22b. ADDRESS Cabool, Mo.		22c. DATE SIGNED 1-29-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/29/62	23c. NAME OF CEMETERY OR CREMATORY Cabool Cemetery		23d. LOCATION (City, town, or county) Cabool, Mo.		(State)	
24. FUNERAL DIRECTOR Elliott-Gentry,		ADDRESS Cabool, Mo.		25. DATE RECD. BY LOCAL REG. 1-30-62		25. REGISTRAR'S SIGNATURE Jaynell Cunningham	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. O. Embalming

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.